"MAKE OR BUY" Role of Private Sector in Health

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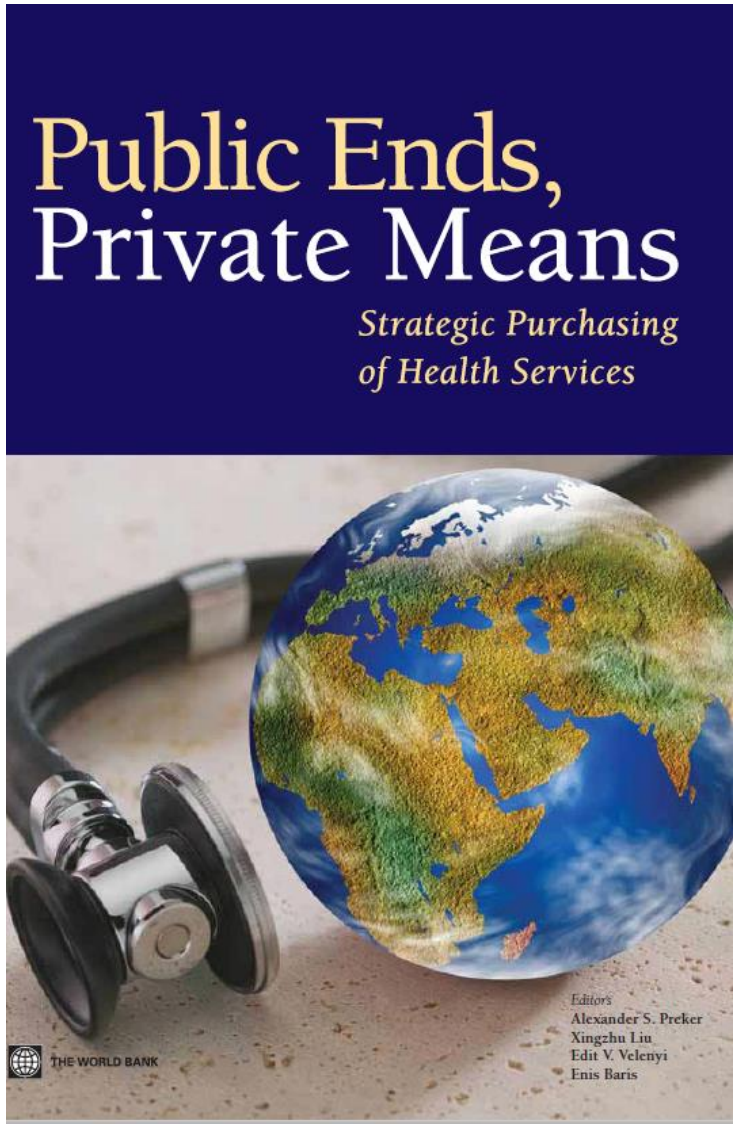
MNA Health Policy Forum, November 12, 13 2017

Based on the chapter: Political Economy of Strategic Purchasing



The Question

Is it possible to know which goods, services better produced by public sector, which services bought efficiently from nongovernmental, private providers?

The question is how to get from here to there

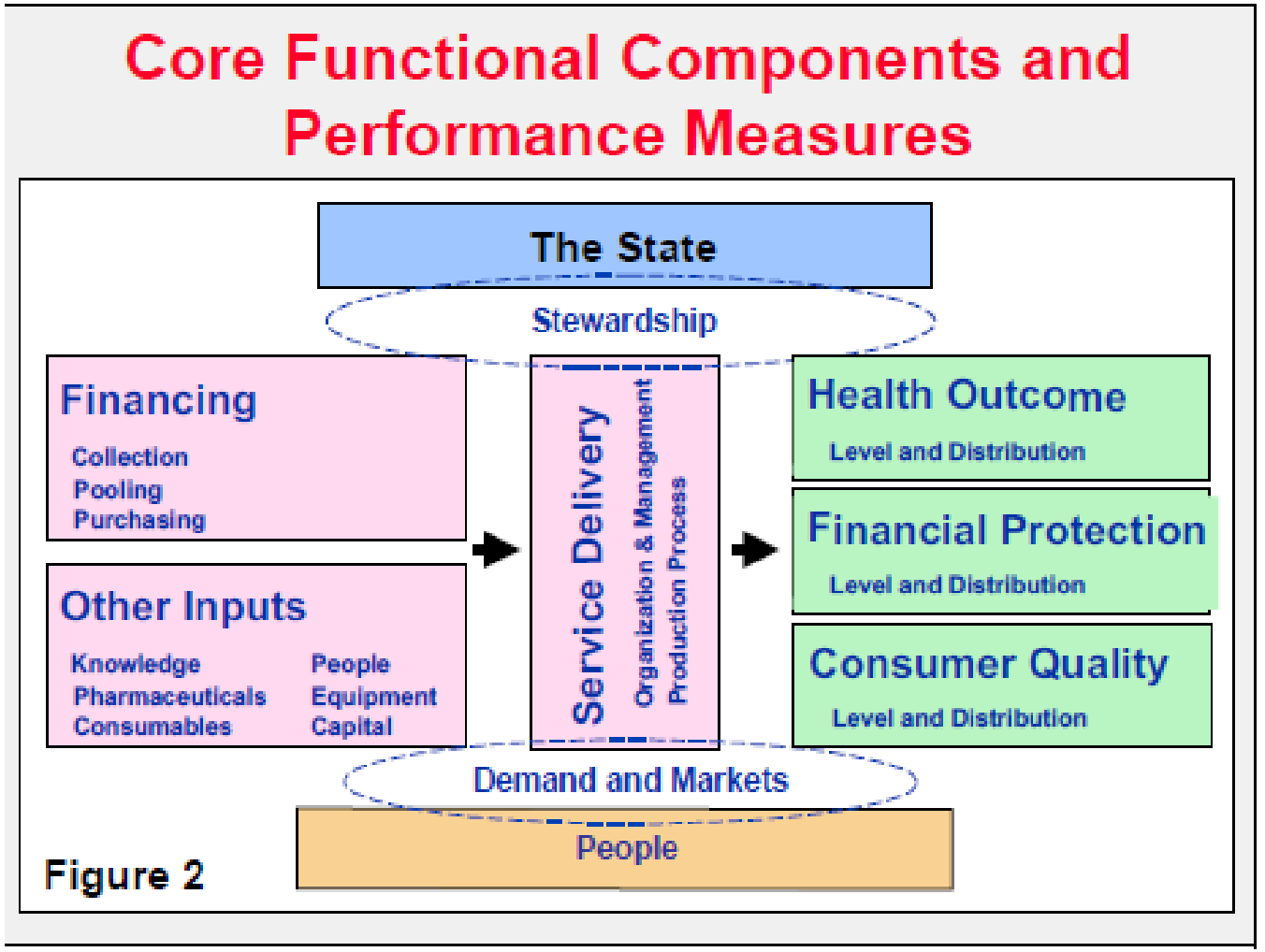
Not a question of deciding if private sector can contribute to broader health objectives, already does so

Moving from a public sector monopoly to a more effective balance between public and private roles is not easy

- Large, inefficient public sector produces goods and services that could be bought from nongovernmental providers
- Could benefit from greater private sector participation in both
  - **factor markets** (production of inputs)
  - **product markets** (provision of services).
- Takes time, accompanied by capacity building
  - contracting
  - Regulation
  - coordination of nongovernmental providers

Public Sector Participation in Health

Weakness in core functions of health systems—*financing, generation of inputs, and provision of services*— leads to policies and programs that fail to reach the poor



In the 20th century, governments became central to health policy, often both financing and delivering care

Such an engagement was justified to secure:

- ***efficiency***—since significant market failure exists in the health sector
- ***equity***—since individuals and families often fail to protect themselves adequately against the risks of illness and disability on a voluntary basis

To improve efficiency or equity, governments can choose from an extensive range of actions—from least to most intrusive

What we expect governments to do

- **Provide information,** influence behavioral changes
- **Develop/ enforce policies & regulations,** influence public/ private sector activities
- **Issue mandates**
- **Purchase services,** from public/ private providers
- **Provide subsidies**
- **Produce preventive and curative services**, in certain cases

However governments often try to do too much with too few resources and little capability

What well-intending governments often fail to do

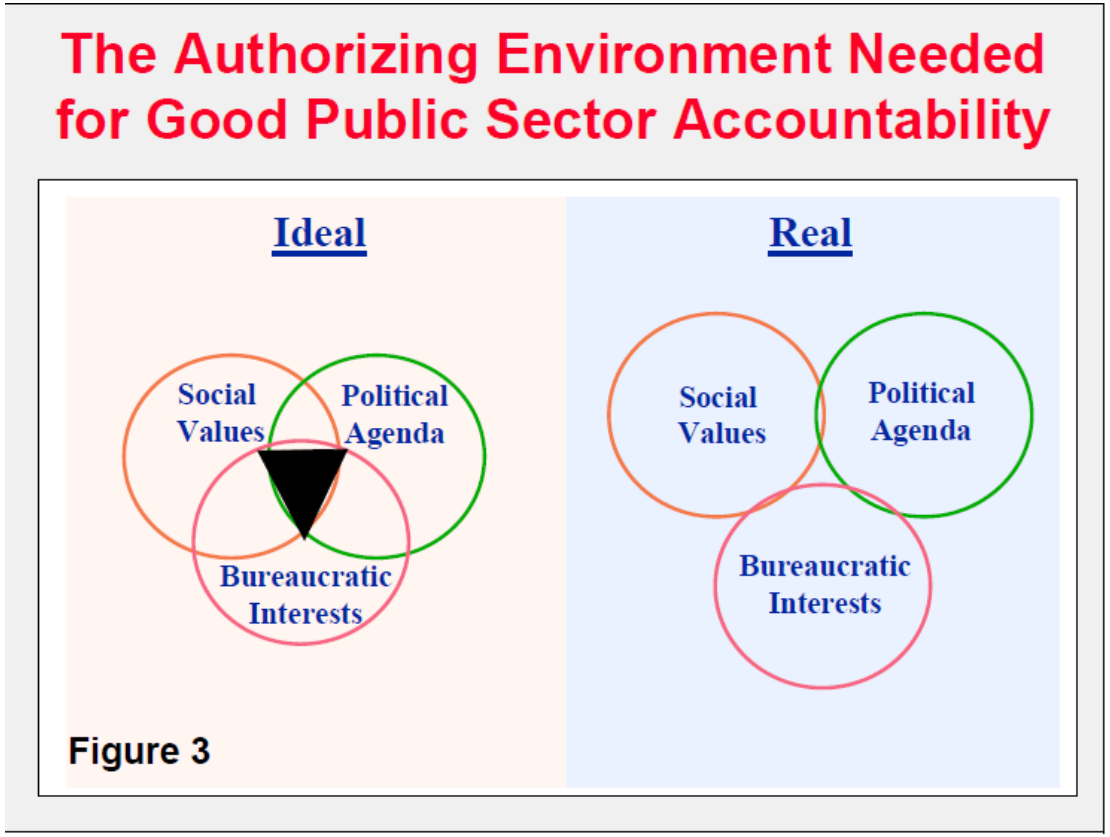
- **Develop effective policies**
- **Make available information** about personal hygiene, healthy lifestyles, and appropriate use of health care
- **Regulate/ contract** private sector providers
- **Ensure adequate financing** for whole population
- **Secure access to public goods with large externalities** for whole population

THE NATURE OF GOVERNMENT FAILURE

Problems Relating to Public Accountability

Good public accountability secured through intersection between homogeneous social values, political agenda reflecting such values, vested bureaucratic interests

Accountability will be imperfect, aggregates never perfectly homogeneous individual values



Information Asymmetry in the Public Sector

Information asymmetry can occur in three major ways

- ***Between patient and provider***
  - Patients know symptoms; doctors know causes, prognosis, effectiveness of treatments. Patients and Doctors may not communicate clearly
- ***Between patient and administrator***
  - Patients conceal pre-existing conditions; Administrators lack transparency in rationing of scarce resources
- ***Between provider and administrator***
  - Providers have better understanding of legitimate needs or demands of patients; Administrators have better understanding about supply, cost of resources, know little about intervention's appropriateness or effectiveness

Information Asymmetry in the Public Sector

Leads to:

- Higher Transaction Costs
- Potential for Corruption

Abuses of Public Monopoly Power

Exhibits negative features:

Leads to reduction in output, quality, while raising prices with incentives to lower expenditures

Failure of Critical Policy Formulation

Government is needed for these goods:

- public goods (policymaking and information)
- goods with large externalities (disease prevention)
- goods with intractable market failure (insurance)

However,

- Governments busy producing curative services that private sector can provide
- Spending public funds on poorly targeted public production
- Leaving few or no resources for strategic purchasing of services for the poor from nongovernmental providers

The Nature of Goods

An optimally functioning market will result in a welfare-maximizing situation

The Assumption

- Competitive forces will lead to a more efficient allocation of resources than nonmarket solutions
- <u>For that to happen:</u>
  - Goods involved behave like private goods
  - Rights can be perfectly delineated
  - Transaction costs are zero

Goods: What is Public and What is Private?

Private goods exhibit

- **Excludability:** consumption by one individual prevents consumption by another— no externalities
- **Rivalry:** competition among goods based on price
- **Rejectability:** individuals can choose to forgo consumption

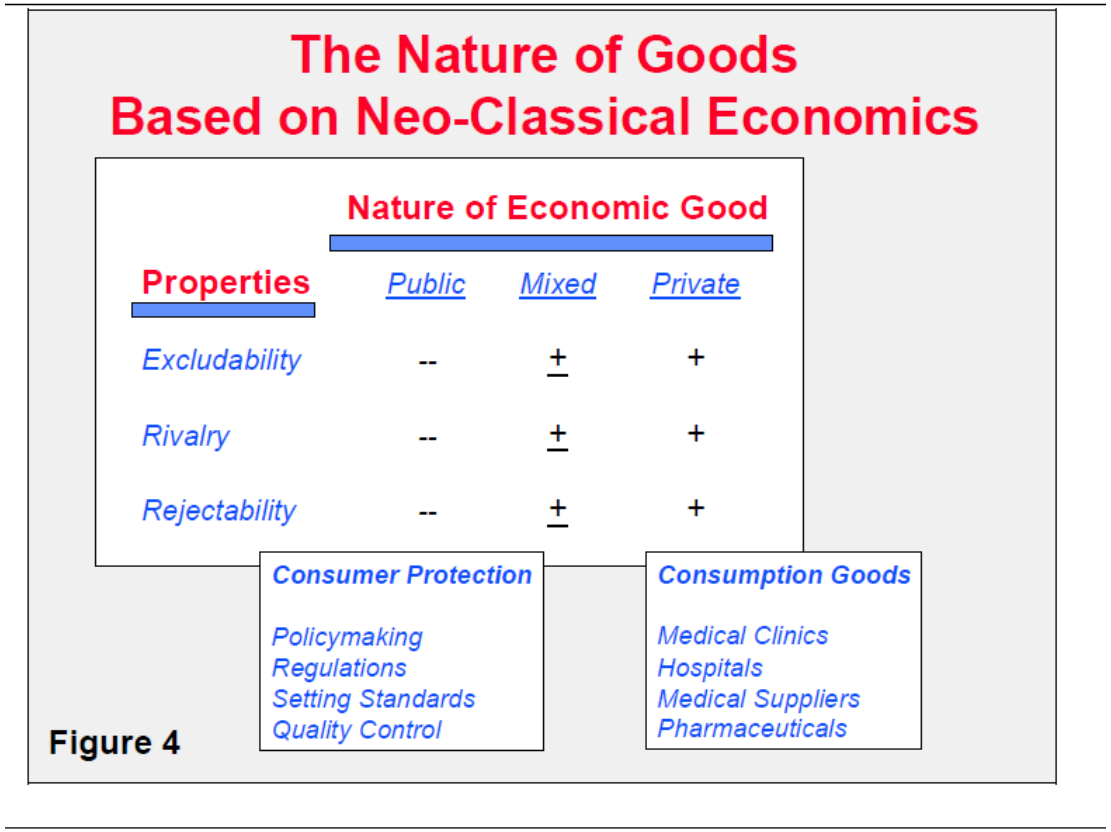


Figure 4

Goods: What is Public and What is Private?

True public goods have significant elements of nonexcludability, nonrivalry, and nonrejectability

Mixed goods have some but not all of characteristics of private goods

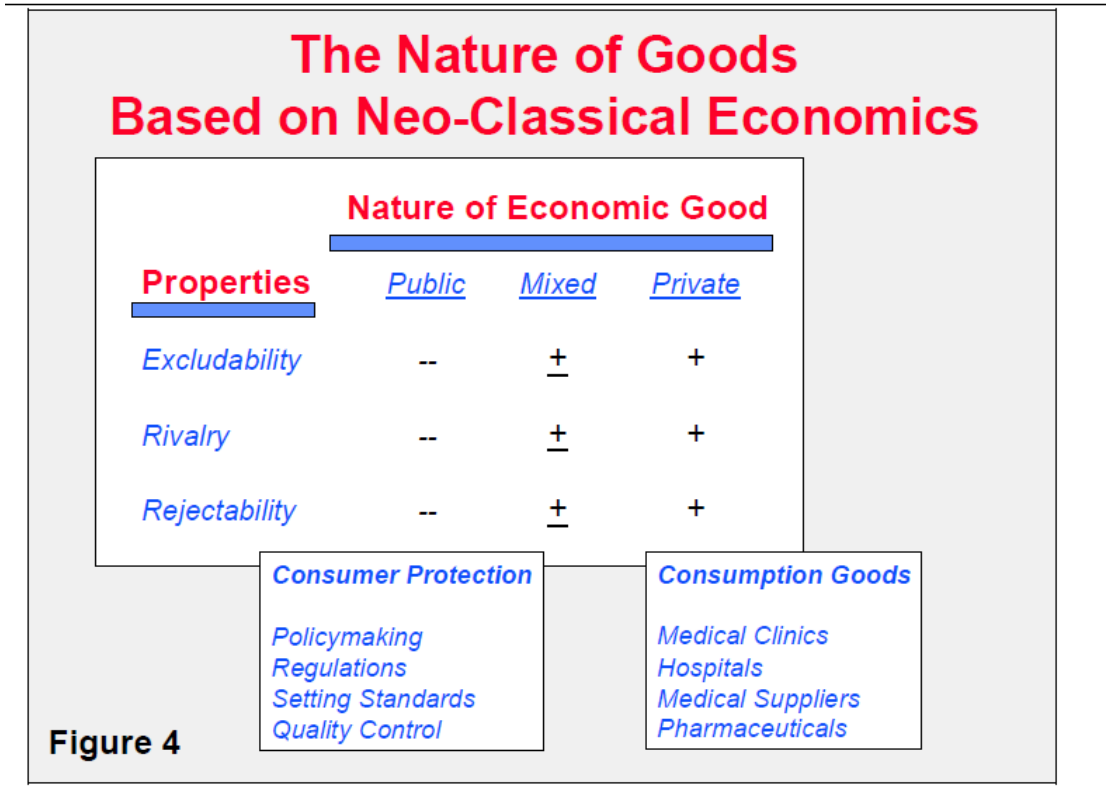


Figure 4

A breakdown occurs in both efficiency and equity when

- Public goods or services with significant externalities are allocated through competitive markets
- Private goods are produced or provided by a public sector monopoly

- Many public health activities generate significant externalities, not pure public goods (sanitation services, control and prevention of communicable diseases, and health promotion)
- Expensive diagnostic and therapeutic care—often provided in publicly owned inpatient facilities at highly subsidized rates—is private good, hence marketable, same is true for ambulatory, community-based care
- When governments try to control market for such services, preventing their sale in informal economy is difficult

Production Characteristics of Goods and Services

Contestability & Measurability

- **Contestability,** where firms (their goods) can enter market freely without resistance, exit without losing investments
- **Measurability,** precision with which inputs, processes, outputs, outcomes of a good or service can be measured
- Difficult to measure output and outcome of health services characterized by high degree of information asymmetry

Health care goods and services, categorized on a continuum

high-contestability/ high measurability services, low-contestability/ low measurability services

Addition to significant information asymmetry

Production Characteristics of Inputs (Factor Markets)

Figure 6

	High Contestibility	Medium Contestibility	Low Contestibility

High Measurability	Type I
	• Production of Consumables
	• Retail of
	  • Drugs & Equipment
	  • Other Consumables
	• Unskilled Labor
		Type II
		• Production of Equipment
		• Wholesale
		  • Drugs & Equipment
		  • Other Consumables
		• Small Capital Stock
			Type III
			• Production
			  • Pharmaceuticals
			  • High Technology
			• Large Capital Stock

Medium Measurability	Type IV
	•
		Type V
		• Basic Training
		  • Skilled Labor
			Type VI
			• Research
			  • Knowledge
			• Higher Education
			  • High Skilled Labor

Low Measurability	Type VII •	Type VIII •	Type IX •

Production Characteristics of Outputs (Product Markets)

Figure 7

	High Contestibility	Medium Contestibility	Low Contestibility
High Measurability	Type I •	Type II •	Type III •

Medium Measurability	Type IV
	• Non Clinical Activities
	  • Management Support
	  • Laundry & Catering
	• Routine Diagnostics
		Type V
		• Clinical Interventions
		• High Tech Diagnostics
			Type VI
			•

Low Measurability	Type VII
	• Ambulatory Care
	  • Medical
	  • Nursing
	  • Dental
		Type VIII
		• Public Health Interventions
		• Intersectoral Action
		• In-Patient Care
			Type IX
			• Policymaking
			• Monitoring/Evaluation

“MAKE OR BUY”

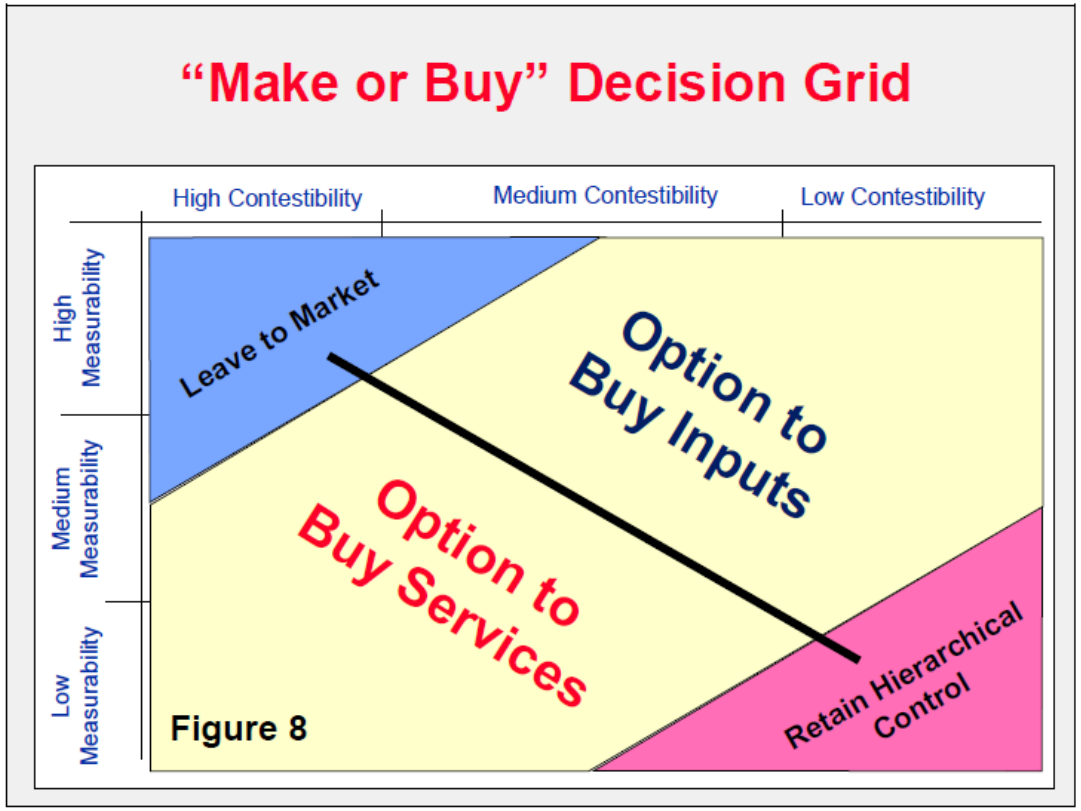
Set Priorities First …

- Priorities specify range of interventions to finance through public resources, ensure public subsidies appropriately targeted
- Countries, not to rush into "make or buy" decisions before setting priorities

… Then Decide Who Can Produce What

Map goods and services:

- can be bought
- where coordination is enough
- better produced by the public sector



… Finally Decide From Whom to Buy and How

- Once "make or buy" options have been settled, the next questions relate to:
  - whom to buy from
  - how to structure the purchase

Whom to buy from

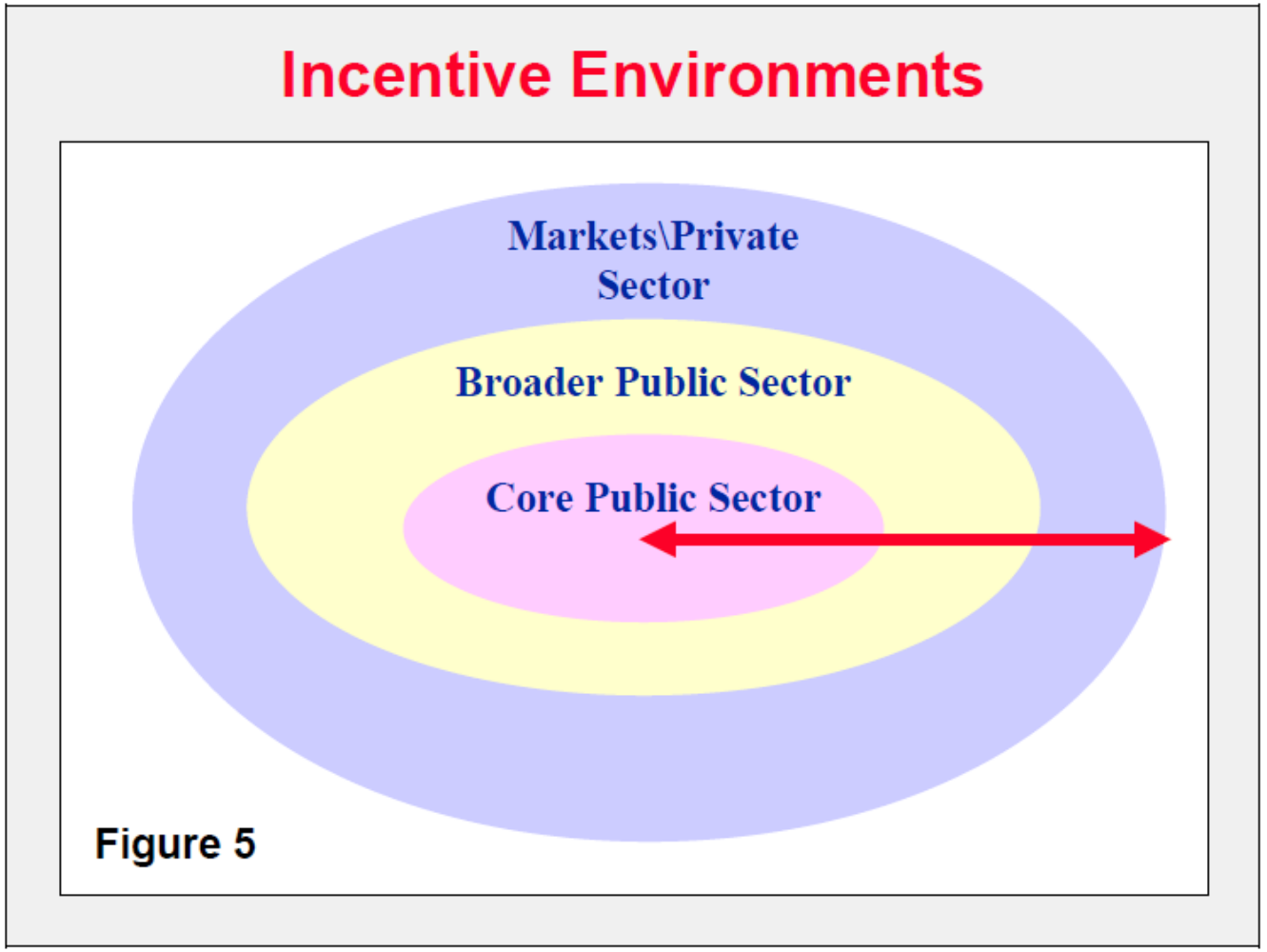
- Consider all possible producers
- Base purchase on best product at lowest price responsive
- **No market**, stimulate demand rather than in-house production.
- N**o competitive market (**low contestability), use benchmark purchasing (estimated reference costs)
- **Dysfunctional market**, improve function through appropriate incentives (strategic subsidies) or regulations (antitrust)

And how to buy

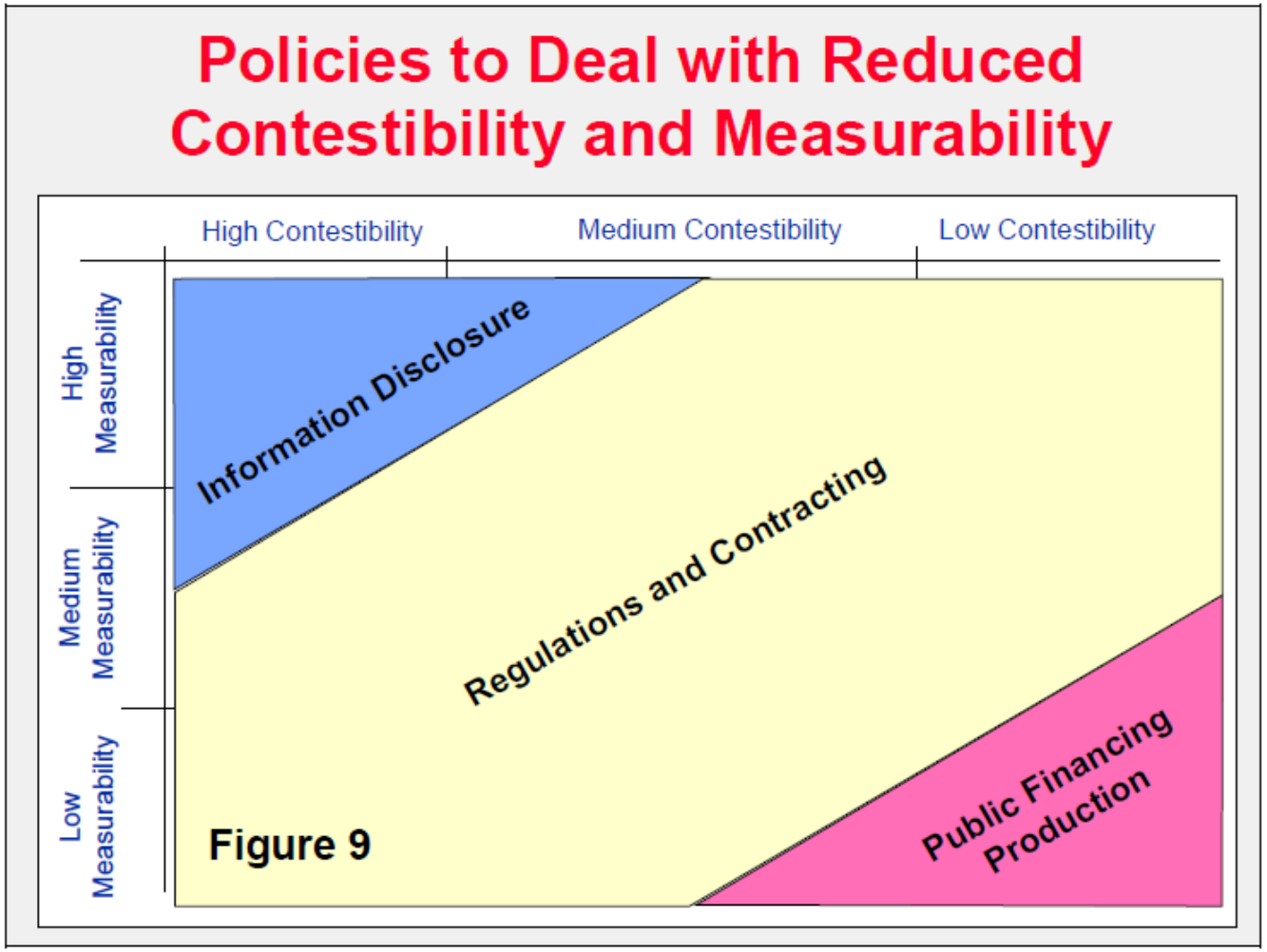
- Choose contractual arrangement most suitable for a given purchase
- All potential producers to be treated alike

POLICY LEVERS AVAILABLE TO GOVERNMENTS

Incentives for efficient production,
higher moving toward the periphery, where service delivery is better



Standard Policy Instruments



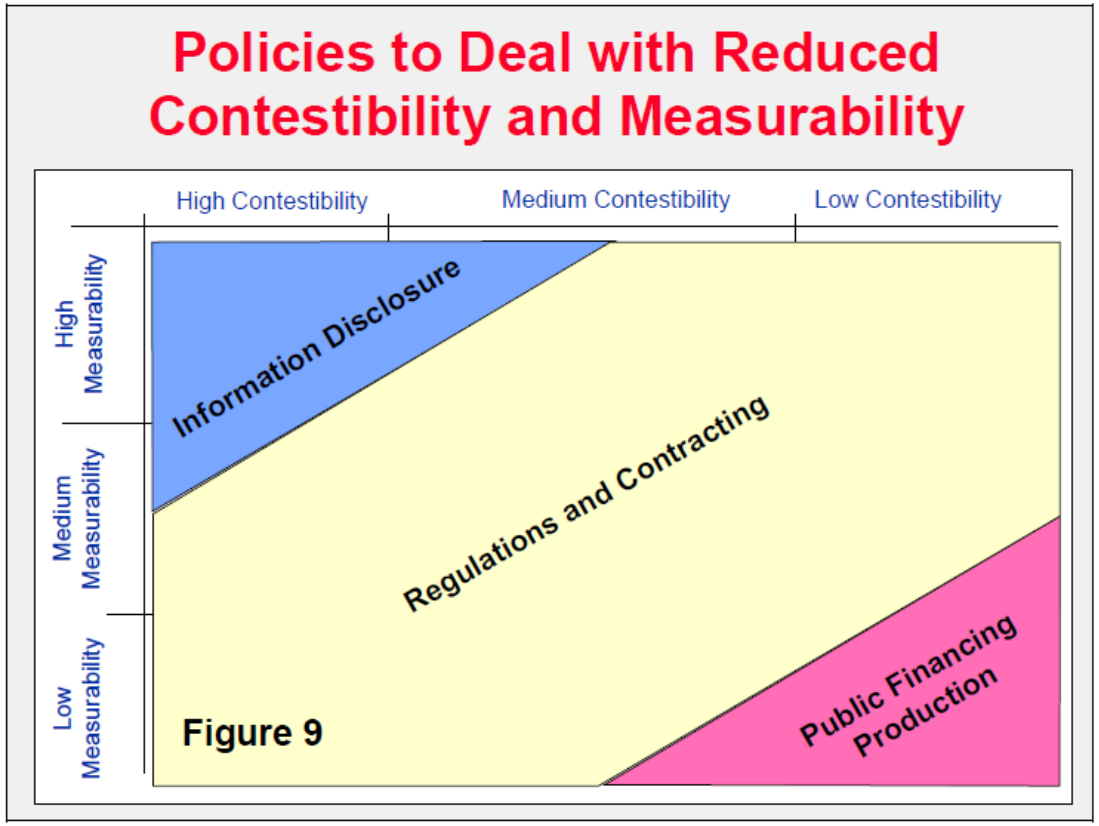
Standard Policy Instruments

Factor markets (Inputs/ Goods)

Inputs with few market imperfections, best produced within competitive markets, minimal government intervention (information disclosure, quality or safety standards)

Inputs with considerable market imperfections, mix of strong regulation, in-house production to ensure adequate generation of inputs

Inputs with moderate contestability, measurability, skilled use of regulations, contracting mechanisms needed for purchasing



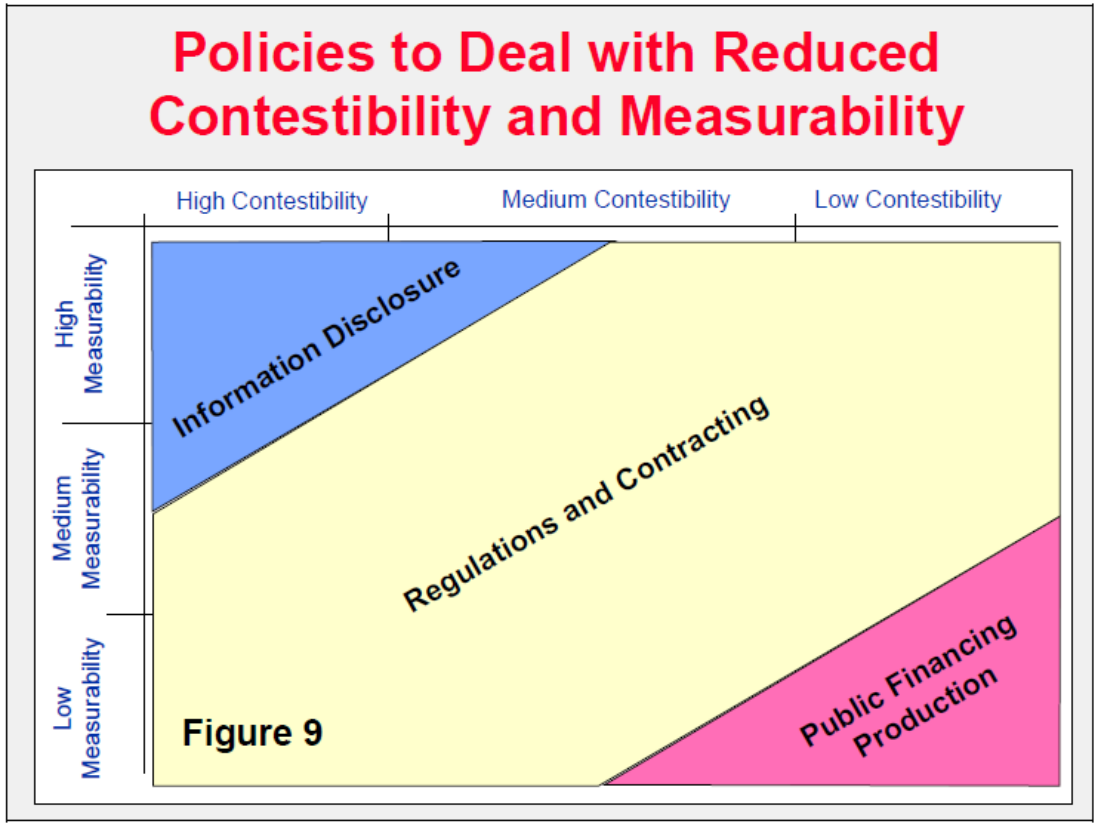
Standard Policy Instruments

Product markets (Services)

Production of interventions can be "contracted out" (purchased), not produced in-house

Which to make in-house, which to contract out is complicated

- Some outputs harder to specify than inputs
- Contestability often reduced
- Complex health problems require strategic coordination among interventions (integrated care, continuity of care, appropriate and timely referrals)

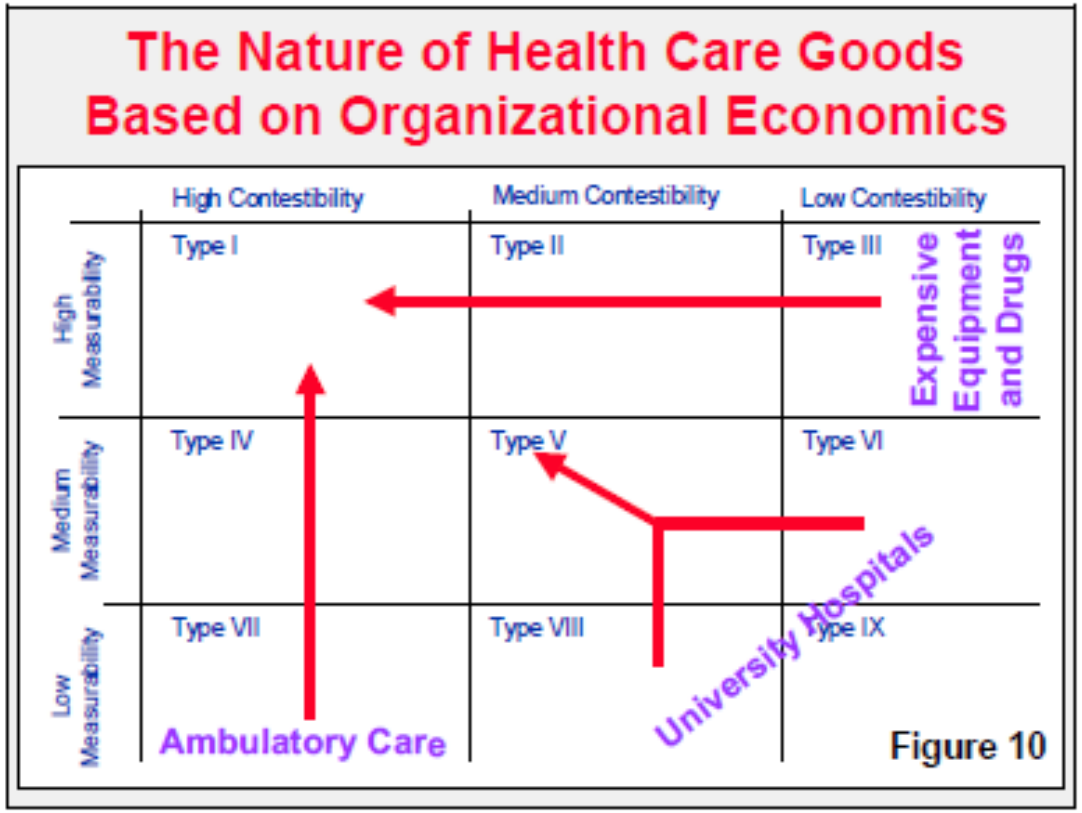


Other Policy Levers

- ***Governance:*** relationship between owner (governments), health care organizations
- ***Market environment:*** competition for goods, services markets
- ***Purchasing mechanisms:*** funding, payments arrangements for goods or services

Governance and Internal Incentive Regime

Changes in *governance* influence characteristics of health care goods, services characteristics by enhancing nature of their contestability and measurability

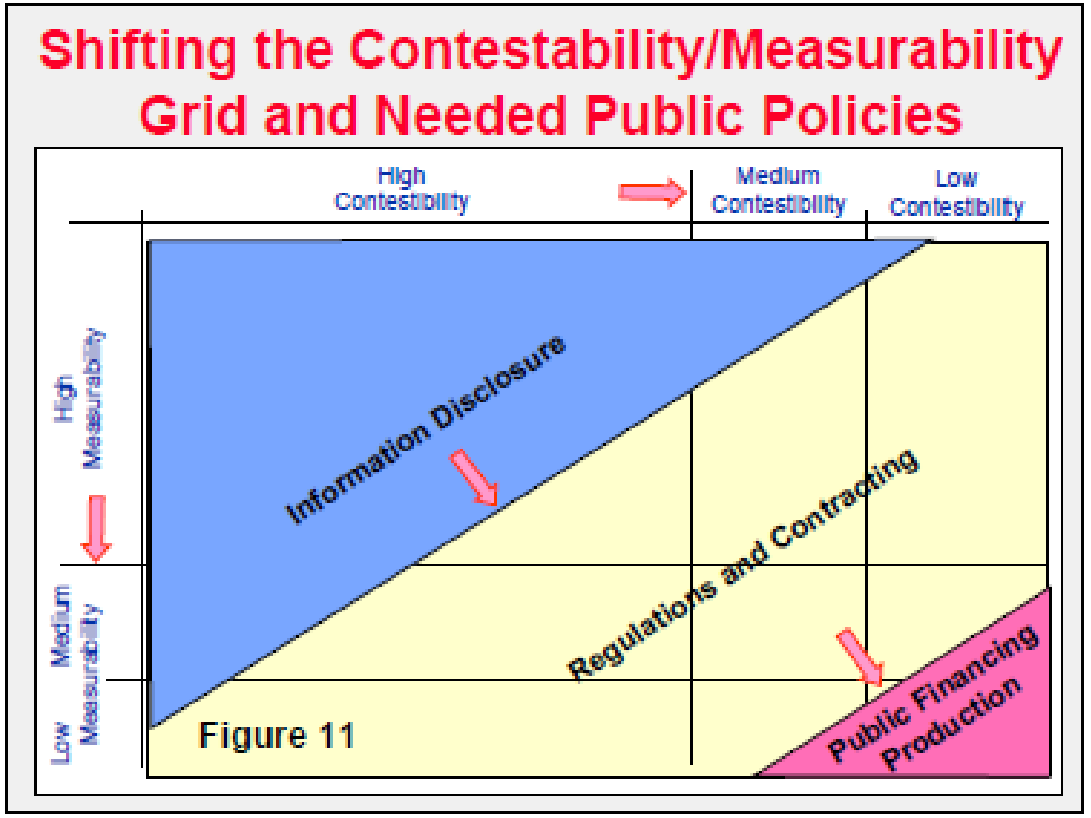


Market Environment

Policies influencing competitive environment through regulations or contracting can alter contestability of health care goods and services

Information asymmetry can be reduced by

- increasing availability of good information on services,
- enhancing health care providers' institutional capacity to deal with information
- improving patients' understanding about health problems



Market Environment

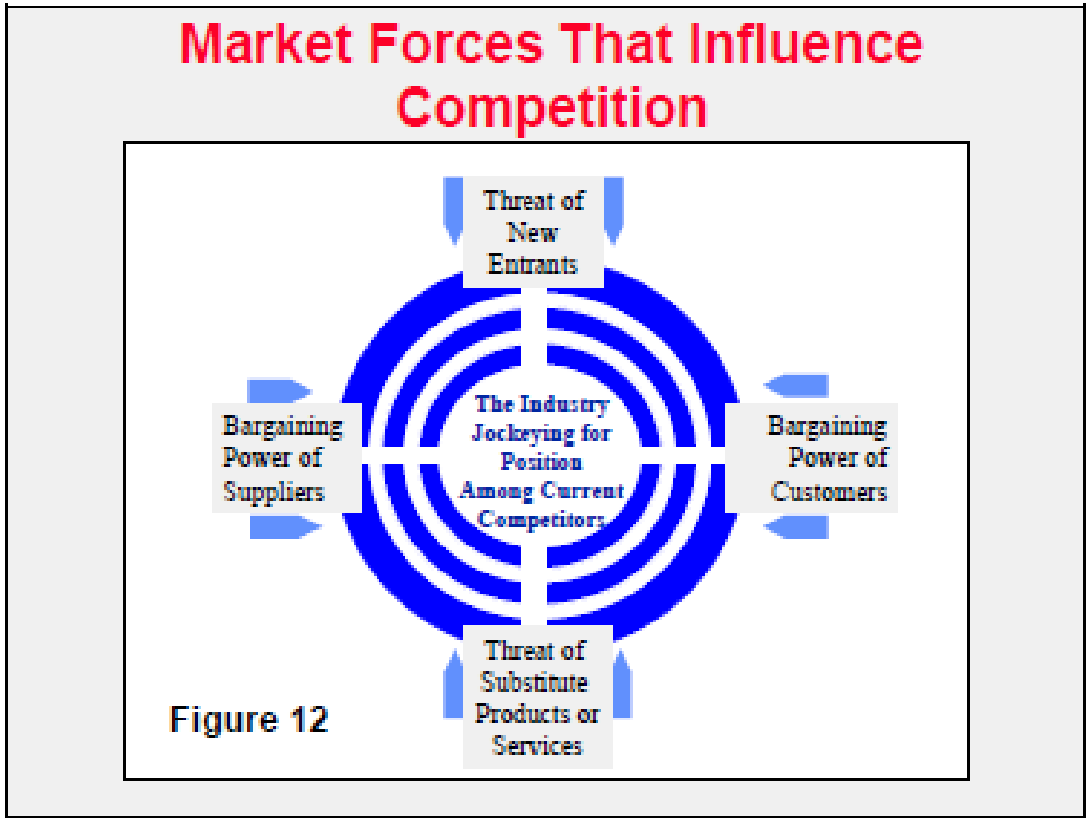
Market Imperfections In Service Delivery

- Two related problems in market structure of service delivery in most segments of health sector
  - Little or no competition may emerge—reducing pressures on provider to deliver "value for money" to maximize profits
  - Alternatively (or in addition), competition may emerge, but may be dysfunctional

Market Environment

Market Imperfections in Service Delivery

Information asymmetry in the health sector exacerbates these problems, can be corrected through appropriate regulations and contracting arrangements



Market Environment

Market Imperfections In Service Delivery: Examples

- Medical treatment is a "bundled" good where doctor guides patients' consumption decisions
- Providers use their information advantage to control a rigid, lucrative referral chain
  - Doctors may "**forward integrate**" into diagnostic labs, pharmacies; steer patients toward consumption where a financial stake
  - Hospitals may "**backward integrate**" creating strong links with doctors, cornering part of market where little or no competitive pressure
  - Medical professionals able to create cartels, limiting competitive pressures that strengthen influence of patients and purchasers

Market Environment

Market Imperfections In Service Delivery: Examples

- Patients/ payers know less than providers about value or cost of health services, providers can cream-skim, select patients who cost less to treat
- Providers increase profits, not by delivering better service to capture market share or cutting costs but by choosing more profitable patients.

Market Environment

Market Imperfections In Service Delivery: Examples

- Equal access to capital and antitrust legislation, limiting the power of professional cartels, can significantly decrease the entry barriers for some segments of the health care market, especially for clinical services that fall in the middle band of the contestability/ measurability grid.
- Same would be true for contracting practices that are open to both public and private providers and which leave open possibilities for choosing alternative providers or exercising "exit" strategies.
- In other instances, supplier cartels, combined with low quality-control standards, shift activities such as retail sale and distribution of pharmaceuticals and medical equipment into the lower right corner, even though such activities belong in the upper left area of high contestability and measurability.

Market Environment

Market Imperfections of Private Health Insurance

- Private voluntary health insurance prone to market imperfections, many related to information asymmetries
  - Insurance may protect some people against selected risks, fails to cover everyone, excludes individuals needing health insurance the most or who greatest risk of illness
  - Insurers have strong incentive to enroll healthy or low-cost clients (risk selection or cream-skimming), excluding costly conditions, minimizing financial risk using caps, exclusions limiting protection against expensive/ catastrophic illnesses

Market Environment

Market Imperfections of Private Health Insurance

- **Adverse Selection**, at risk individuals conceal underlying medical condition
- **Free-riding,** healthy individuals pay low premiums, deliberately underinsure themselves, hoping free or highly subsidized care be available when ill, preventing insurers from raising funds for expenses incurred by sicker or riskier members
- **Moral Hazard,** when third-party insurers pay, both patients and providers become less concerned about costs, become careless about maintaining good health leading to more use of care, less effective care, or not needed care

Purchasing Mechanisms

- Provider payment systems influence goods properties
- Service providers respond differently to alternative funding and payment mechanisms.

GETTING FROM HERE TO THERE

When large private sector present

Public sector recognizes its existence, increase its use through better coordination, contracts, positive regulatory environment

Once learning, transfer positive lessons to priority areas where nongovernmental providers are not active

Where public sector is engaged in inefficient activities

Buy from private sector

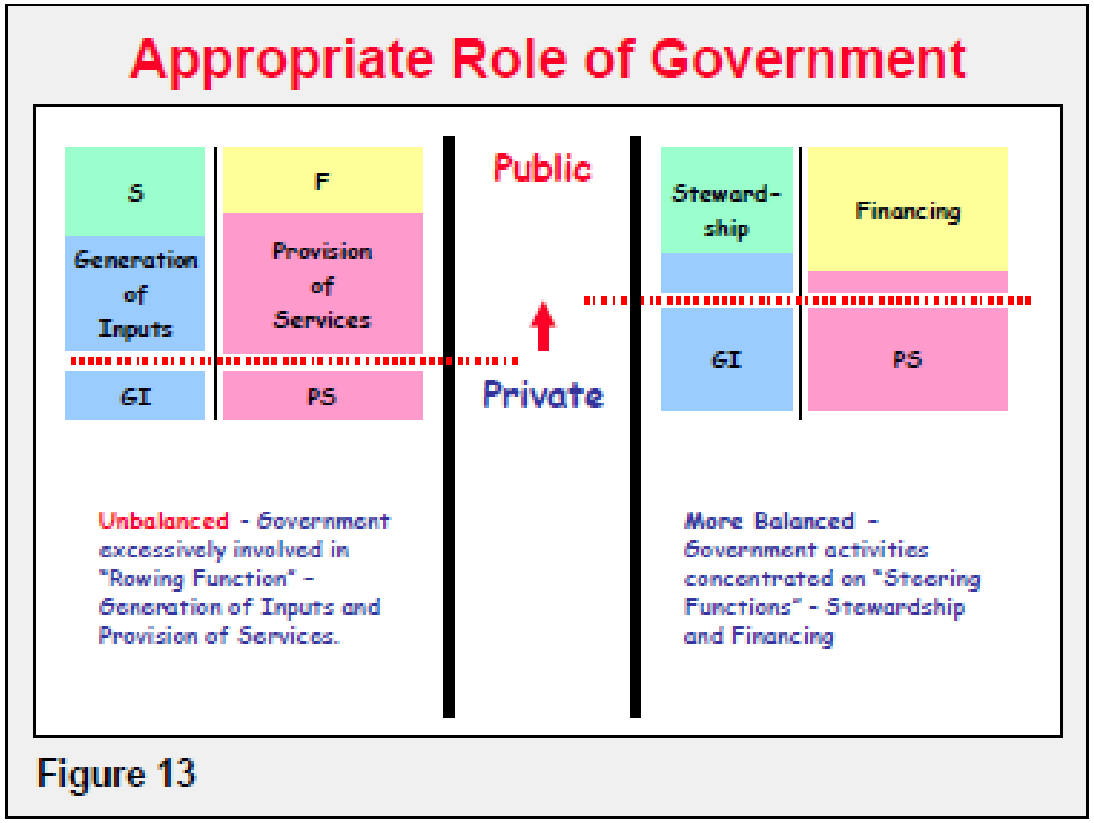


Figure 13

GETTING FROM HERE TO THERE

Public sector to be involved in areas of strategic importance: securing financial protection against cost of illness, providing sectoral oversight in terms of stewardship function

Parallel to moving out of production of goods and services, move to integrated approach and greater public sector involvement in health care financing, sectoral coordination, regulation, monitoring, and evaluation

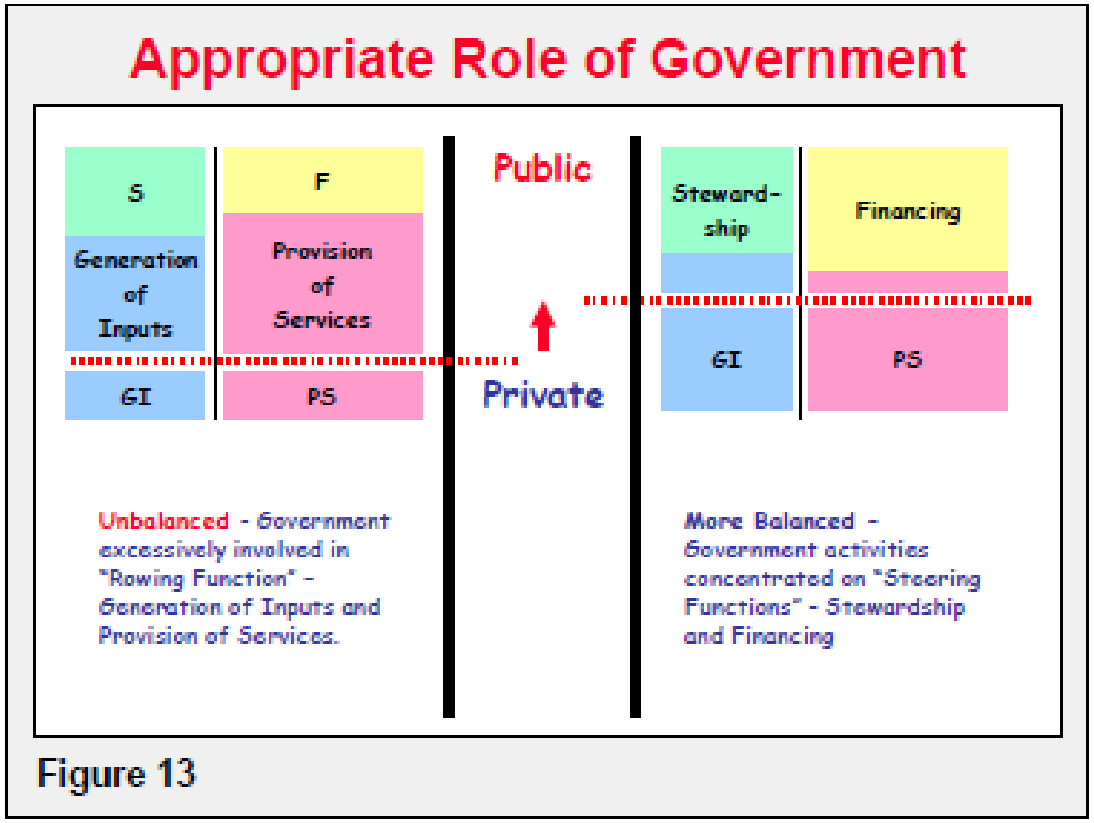


Figure 13

THANK YOU